Section VIII

ALLIANCE HEALTHCARE SERVICES AND MEMBER UTILIZATION

The creation of the DC Healthcare Alliance gave rise to new concepts and methodologies for healthcare provision that now form the core of the healthcare delivery system for the uninsured residents of the District. The challenge of creating an organization that would increase access, assure quality, and improve health outcomes resulted in a:

- New service delivery structure that uses a patient-centered care model as a guiding principle for care
- New program that now provides services only to DC residents
- New and expanded array of service delivery sites that includes 6 network hospitals, 28 neighborhood clinics, and 781 primary care providers and specialists
- New and extensive network of hospital and emergency services that coordinates services with each member's medical home PCP for continued focus on primary care and disease prevention
- System for data collection and reporting that provides information regarding the cost, disease status, treatment, and utilization of the services provided through the Alliance.

The Alliance has established 12 months of claims and enrollment data that reflect the paid services received by enrolled members but it is still in its infancy.

This section will provide an overview of the first 12 months of services and make comparisons, where possible, to the service utilization at the former DC General Hospital (DCGH) to gain an understanding for:

- Who is using Alliance healthcare services?
- Who is providing Alliance healthcare services?
- Which services are being used?

Who Is Using Services?

Year 1 - DC Healthcare Alliance Operations June 2001 to May 31, 2002

- Enrollment totaled 37,614
- 21,679 of the 37,614 Alliance members received healthcare services
- The overall Alliance healthcare service utilization rate was 58 percent.[1]

Source: HCSNA DW, claims data June 2001 to May 31, 2002 for claims paid through August 2002.

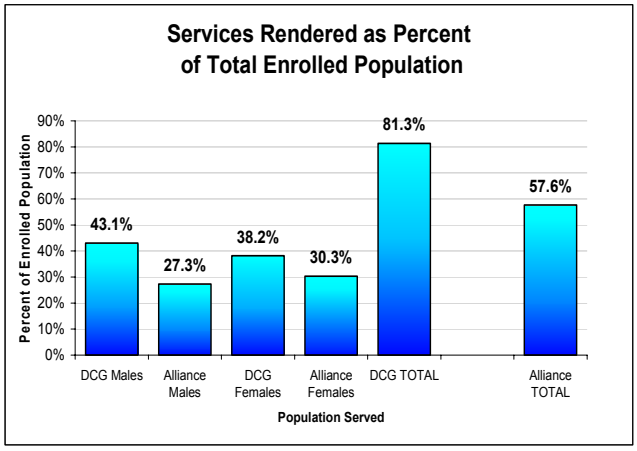
While the overall utilization numbers for the first year of operation of the Alliance are comparable to the DC Medicaid program and several other state Medicaid programs, it is much lower than that observed in the DCGH proxy population.[2]

[1] The utilization rate increased to 68 percent for the period of 2001 to May 31, 2002 for claims paid through September 2002.
[2] Please refer to "Introduction: Important Notes Concerning the Data" for a full description of the DCGH Proxy Population.

DCGH Proxy Population
1/2000 to 7/15/2001

- Enrollment totaled 37,972;
- 30,881 of the 37,972 DCGH patients received healthcare services
- The overall DGCH proxy population utilization rate was 81 percent.

Source: HCSNA DW, claims data June 2001 to May 31, 2002 for claims paid through August 2002.



Note: HCSNA DW: Time Period 06/01/01 through 05/31/02 for claims paid through August 2002.

Gender

The Alliance male-to-female enrollment ratio is nearly equal. However, when health service utilization is examined by gender, Alliance female members used slightly more services than males and account for more of the services used by the total population during the first year. The opposite findings occurred in the DCGH proxy population:

- Females used 53 percent of the total services that were provided by the Alliance, vs. males who used 47 percent of the total services
- Females who received services from the Alliance represent 30 percent of the total enrolled population; vs. the 27 percent represented by males who received Alliance services
- Females used 47 percent of the total services that were provided by GCGH, vs. males who used 53 percent of the total services
- Females that received services from DCGH represented 38 percent of the total enrolled population, vs. the 43 percent represented by males who received DCGH services.

Table 8.1 Alliance Health Care Service Utilization by Enrollment and Gender

	Alliance					DCGH Proxy Population				
Gender	Number Enrolled	Number That Utilized Services	UR by Gender	UR for Enrolled That Received Services	UR for Total Number Enrolled	Number Enrolled	Utilized Services	UR by Gender	UR for Enrolled That Received Services	UR for Total Number Enrolled
Female	18,896	11,407	60%	53%	30%	17,455	14,510	83%	47%	38%
Male	18,718	10,272	55%	47%	27%	20,517	16,371	80%	53%	43%

HCSNA DW; Time Period 06/01/01 through 05/31/01 for claims paid through August 2002.

Conclusion

The DCGH proxy population's overall healthcare service rates were 23% higher than the Alliance. This rate of service use is likely related to the longer timeframe for data collection in the DCGH proxy population, the established nature of the DCGH service setting, and an absence of eligibility protocol required for health plan enrollment. While the DCGH proxy population represents the former hospital population that is similar to the current Alliance, the data corresponds to services provided to those who presented with illness. The Alliance data represents a health plan population who is enrolled for future healthcare services and uses them as needed.

We expect to see greater utilization of services by the eligible population. As the Alliance program matures, members settle into their medical homes, and the number of presumptive eligible members stabilizes. This is currently the trend in the nonpresumptively eligible Alliance population where the overall percent of members receiving services is 63%. (Please refer to the section on presumptive eligibility.) This is an area for continued Alliance monitoring and oversight for the HCSNA.

Recommendations

The Alliance made major strides in collecting data on enrollment and utilization. The following recommendations will enable the HCSNA and the Alliance to continue to focus on these issues:

- Continue to monitor utilization rate by overall use, by gender, age and ward
- Provide results to the Alliance to promote utilization by age and location.

Who Is Providing Services?

During the first year of operation, the Alliance network expanded to include 6 network hospitals, 28 neighborhood clinics, and 781 primary care providers and specialists. The provider network focused on primary care and preventative health services. However, specialty care was also central to providing disease-specific healthcare for the Alliance population. In total, physician services made up 57 percent of the overall claims.[3]

Primary Care Services

The greatest number of healthcare services provided to Alliance members were supplied by primary care providers. From June 2001 through May 2002, outpatient (OP) physician providers supplied 28% of the overall services, which accounted for the following:

- 34,295 outpatient primary care services
- 28 percent of the total annual claims
- 36 percent of the enrolled members received these services
- $3,932,215 was paid for these services
- The amount paid for primary care services represented13.8 percent of the total sum paid for all healthcare services in the first year.
- Two provider groups supplied 87 percent of the outpatient primary care physician services. (Please refer to Table 8.2.) Unity Health Care, Inc. (UHC) provided 70 percent of all paid services, and GSECH/DCGH Specialty Clinics provided an additional 17 percent.

[3] This includes the physician claims that were part of the one time supplemental payment (OTSP) made in the first year of operation and services provided to the Corrections population. (Please see Program Description article.)

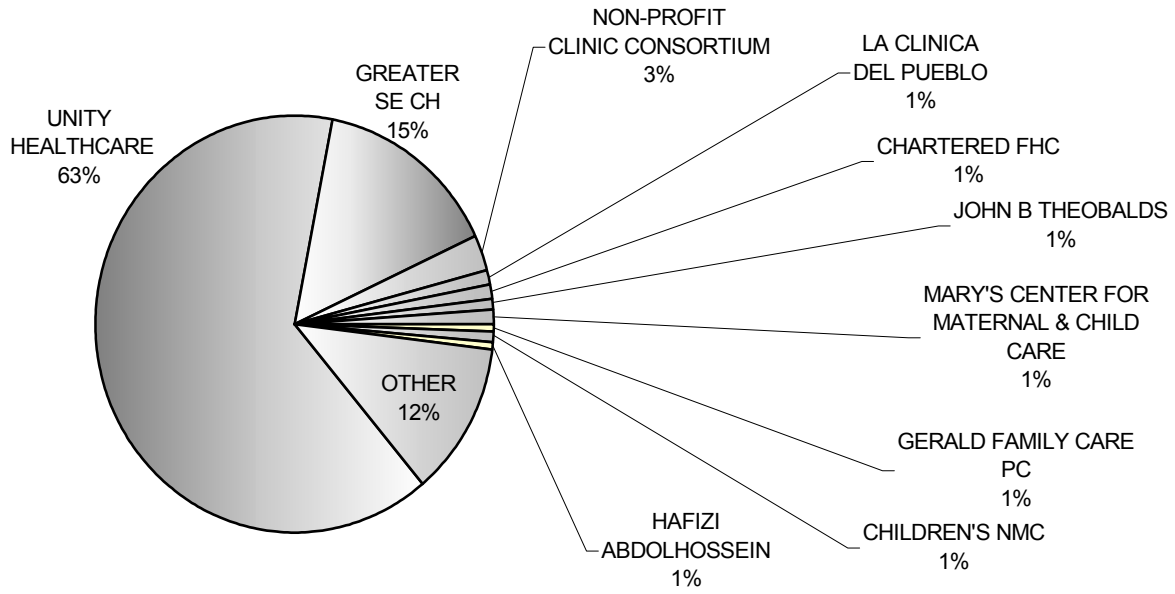
Table 8.2 Healthcare Alliance Annual Monitoring Report
Alliance Utilization by Vendor Type: Top Ten Outpatient Physician PCP

Vendor Location	Number of Claims	Top Vendor Claims (percent)	Total Claims (percent)	Total OP Encounters (percent)
Unity Healthcare (UHC)	24,129	73%	70%	64%
Greater SE Community Hospital (GSECH)	5,660	17%	17%	15%
Non-Profit Clinic Consortium (NPCC)	1,150	3%	3%	3%
La Clinica Del Pueblo	551	2%	2%	1%
Chartered Family Health Center	370	1%	1%	1%
John B. Theobalds MD PC	331	1%	1%	1%
Mary's Center for Maternal & Child Care	303	1%	1%	1%
Gerald Family Care PC	278	1%	1%	0.7%
Children's National Medical Center	217	1%	1%	0.6%
Hafizi Abdolhossein	215	1%	1%	0.6%
TOTAL (Top 10 Vendors Claims)	**33,204**	**100%**		**88%**
TOTAL CLAIMS	**34,295**		**97%**	

Note: CHP and Member Database Time Period 06/01/01 through 05/31/02 for claims paid as of October 2002.

Chart 8.2

Percent of Total Alliance OP Encounters (Population Served) by Vendor



Note: CHP and Member Database Time Period 06/01/01 through 05/31/01 for claims paid as of October 2002.

Specialty Care Services

Alliance specialty care providers delivered the second largest volume of services in the first year. From June 2001 through May 2002, OP specialty care providers supplied 24 percent of the overall outpatient services. This is compared with the resource utilization of primary care in Table 8.3 and represented the following:

- 28,820 outpatient specialty care services
- 24 percent of the total annual paid claims, 27.5 percent of the enrolled members received these services
- The $2,649,968 paid for claims submitted for specialty care services represented 9 percent of the total sum paid for all healthcare service claims in the first year.

Conclusion

During the first year of operation, physicians in the outpatient setting provided the bulk of the Alliance healthcare services. However, the majority of these services were provided by a limited number of primary care physicians. Nevertheless, this pattern reflects coordination of primary care services through a single provider site and in keeping with the medical home concept.

As of October 1, 2002, we determined the number of members for whom each PCP has primary responsibility. The number of members ranged from 4000+ members assigned to a clinic site to a single member assigned to a single PCP. (See Table 8.4)

Table 8.3 Comparison of Utilization between Primary Care and Specialty Care

Utilization Indicator	Primary Care	Specialty Care	Total
Number of OP Paid Services by Claim	34,295	28,820	63,115
Percent of the Total Number All of Paid Claims	28%	24%	52%
Percent of the Enrolled Members*	36%	27.5%	-
Total Amount Paid	$3,932,215	$2,649,968	$6,582,183
Percent of the Total Paid for All First Year Healthcare Service Claims	13.8%	9%	23%

**Please note that these numbers do not represent distinct members. A single enrolled member may have received both primary and specialty services, therefore these numbers cannot be totaled for a final percentage of the enrolled members.*

Source: CHP and Member Database Time Period 06/01/01 through 05/31/01 for claims paid as of October 2002.

Table 8.4 Number of Enrollees Assigned Per Primary Care Provider

Number of Alliance members assigned to a single PCP:	1 – 49	50 - 199	200 - 499	500 - 1000	1000 - 2000	4000+
Number of PCPs with this number of members:	175	56	10	6	5	1

Source: CHP and Member Database Time Period 06/01/01 through 05/31/01 for claims paid as of October 2002.

The above PCP assignments were made for 27,364 members to 253 PCPs. While seven of these PCPs were clinic providers, the rest were individual physicians. This is potentially a state of provider overload if all the assigned members are each receiving services and requiring coordination of care by a single provider.

Specialty services also make up a significant percentage of the overall paid claims. We are now unable to determine distinct Alliance members that received specialty care services as a result of a referral from a primary care physician. This is a focus for ongoing monitoring and further analysis in conjunction with the development of the concept of medical homes.

Recommendations

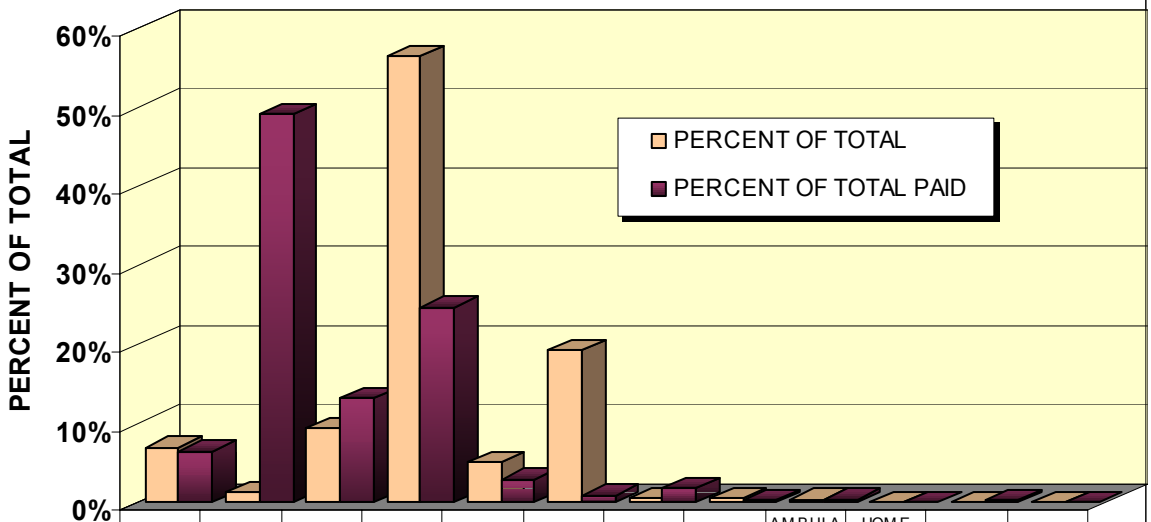
- Continue to monitor the distribution of members cared for by each Alliance vendor
- Determine the ratio of patients to individual providers and track this measure
- Determine the number of distinct members that received primary care and the referrals made for specialty care and monitor this trend
- Assess the treatment frequency based on age group and disease condition for treatment planning and disease management
- Profile frequent disease conditions to benchmark, implement best practices, and access cost efficiency of vendor providers
- Assist new members to select PCPs within the network that have the lowest patient-to-provider ratio.

Which Services Are Being Used?

Overall Service Utilization by Claim Type

The paid services used by Alliance members fall into the service categories of inpatient, outpatient, emergency department, physician, dental, laboratory services, ambulatory surgery, durable medical, ambulance, home care, skilled nursing, and pharmacy[4] outlined below in Chart 8.3. The frequency and distribution of these services is just one indicator of the services that are being used by Alliance members. This chart represents all paid services, from all claims data, provided from June 2001 to May 31, 2002, including claims that were part of the one time supplemental payment (OTSP) made in the first year of operation.

Chart 8.3 **Claim Type with Labs and OTSP Claims and Corrections Comparison Percent of Totals**



	OP	IP	ED	PHYS	DENTAL	LABS	ASC	DME	AMBULANCE	HOME CARE	SNF	RX
PERCENT OF TOTAL	6.98%	1.33%	9.40%	56.49%	5.10%	19.19%	0.57%	0.52%	0.35%	0.04%	0.02%	0.02%
PERCENT OF TOTAL PAID	6.46%	49.12%	13.19%	24.68%	2.90%	0.93%	1.74%	0.23%	0.40%	0.07%	0.24%	0.05%

Source: CHP and Member Database Time Period 06/01/01 through 05/31/01 for claims paid as of October 2002

[4] These are pharmacy services provided outside of the Alliance pharmacy system.

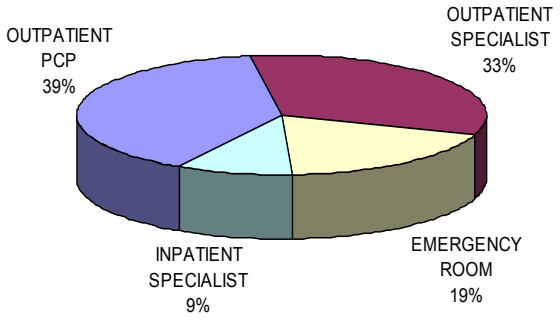
Physician Service Utilization

The paid physician services are depicted by service category below in Table 8.5. This excludes the OTSP, laboratory services, and Corrections Department services data. These services represent:

- $87,727 paid for physician services
- 72 percent of the total annual paid claims
- $8,274,897 paid for physician claims
- 29 percent of the total sum paid for all healthcare service claims in the first year.

The use of physician services per individual member, ranged from a high of 5.5 claims per member for inpatient physicians, to a low of 1.9 claims per member for ED physicians. This indicates that inpatient services are the most resource intensive from a physician service perspective. However, based on the national data for Medicaid managed care, Alliance members do not use services as frequently as their national Medicaid counterparts.[5] It is likely that as this population becomes more accustomed to the concept of a medical home and the number of enrolled members stabilizes, we will begin to see an increase in the proportion of care provided by primary care physicians.

Chart 8.4 ALLIANCE PHYSICIAN CLAIMS



Source: CHP and Member Database Time Period 06/01/01 through 05/31/01 for claims paid as of October 2002

Conclusion

Physician services accounted for nearly three-quarters of the services provided within the first year. The proportion of claims processed in each of the physician service categories is illustrated in Chart 8.4 above. Keep in mind that a single enrolled member is likely to have received services in more than one category of physician service.

Table 8.5 Physician Encounters Per Alliance Member

Physician Service Claim Type	Percent of Total Alliance Population Served	Average Physician Services Per Distinct Alliance Member Treated	National Benchmark*: Physician Encounters per Medicaid HMO Member
Outpatient PCP	36%	2.50	
Outpatient Specialist	28%	2.78	
Physician ED	23%	1.87	
Inpatient	4%	5.50	
Overall	NA	NA	4.0

Source: CHP and Member Database Time Period 06/01/01 through 05/31/01 for claims paid as of October 2002

. This is a national benchmark for plan year 2000 including Medicaid HMOs with 18000+ members. Data Source: SMG Marketing Group Inc. ©2001; includes only physician claims.*

[5] These ratios may be higher if the OTSP and Corrections data were added to the Alliance profile.

Recommendations

- Continue to monitor physician services in the above categories and by medical home
- Continue to monitor the ratio of the number of provided to cost per service claim type
- Provide a focused study to determine the number of patients each PCP actually serves, and the number of referrals received by each member
- Provide a focused study to determine the number of patients each clinic actually cares for, the number of physicians allocated to provide care, the number of referrals and coordinated care, and the number of referrals received by each member
- Review inpatient services provided, and evaluate by case-mixed adjustment
- Profile members with selected critical disease conditions by service category and medical home.

Inpatient Utilization

Including the OTSP and Corrections services data, the inpatient services provided to the Alliance population in the first year, as depicted in Table 8.6, represents:

- 2,128 inpatient discharges
- 1.33 percent of the total annual paid healthcare service claims
- $16,659,687 paid for inpatient claims
- 49 percent of the total sum paid for all healthcare service claims in the first year.

Excluding the OTSP and Corrections services data; the average length of IP stay ALOS for Alliance members is 6.7 days. The ALOS in the Alliance ranged from 5.2 to 7.0 days for the period from August 2001 through May 2002. The monthly trend was a decline in the ALOS. The monthly values were consistently higher than those at the former DCGH for the comparable months in 2000 and 2001. However, the longer length of stay observed in the Alliance could be due to the elimination of inappropriate admissions of ambulatory care sensitive conditions. These generally have shorter lengths of stay.

Table 8.6 Alliance First Year Results Inpatient Services

Operational Measure	IP Discharges Excluding OTSP and Corrections Data	IP Discharges Including OTSP and Corrections Data	National Benchmark	Buncombe Co. Project Access (1997) Statistics as Benchmarks
Number of Discharges	1,621	2,128	NA	NA
Distinct Members	1,401	NA	NA	NA
Discharge per Enrollee	0.043	NA	NA	0.19
Inpatient Paid	$12,891,185	$16,659,687	NA	NA
Cost per Discharge	$7,953	$7,829	NA	NA
Total IP Days	9,668	NA	NA	NA
Hospital Days per 1000 Alliance Enrollees	257	NA	387*	NA

Source: CHP and Member Database Time Period 06/01/01 through 05/31/01 for claims paid as of October 2002.

** This is a national benchmark for plan year 2000 including Medicaid HMOs with 18000+ members reflecting hospital days per 1,000 Medicaid HMO members. Data Source: SMG Marketing Group Inc. ©2001.*

Table 8.7 Average Length of Stay Alliance vs. DCGH			
Month	**Alliance**	**DCGH Baseline**	**ALOS (days) per Medicaid Hospital Admission***
Aug-01	6.7	5.3	NA
Sep-01	6.3	5.5	NA
Oct-01	6.3	6.2	NA
Nov-01	7.0	5.6	NA
Dec-01	6.2	5.5	NA
Jan-02	6.1	5.5	NA
Feb-02	6.1	5.6	NA
Mar-02	5.8	6.2	NA
Apr-02	5.9	5.8	NA
May-02	5.2	5.1	NA
Overall	NA	NA	3.5

**This is a national benchmark for plan year 2000 including Medicaid HMOs with 18000+ members reflecting ALOS (days) per Medicaid Hospital Admission. Data Source: SMG Marketing Group Inc. ©2001*

Conclusion

While inpatient healthcare claims make up less than 2 percent of the overall number of paid claims for the first year of operation, their total dollar value is nearly one-half of the overall payment for annual services. These inpatient services were provided to only about 4-6 percent of the enrolled Alliance population. This frequency, as well as the rate per enrollee and number of days per 1000 enrollees would better reflect values if the OTSP and Corrections claims were incorporated into the overall figures for benchmarking.

We do not have a specific breakdown of the diseases associated with the highest cost inpatient claims. However, the top three inpatient disease conditions for both males and females during the first year were hypertension, heart disease and pneumonia. The top DRG categories associated with inpatient admissions were HIV, heart failure, and Type II diabetes mellitus (please refer to the section, "Alliance Disease Profile)." For the future, it is essential that the high-cost disease conditions be identified along with the most frequent disease diagnoses in order that they are targeted for monitoring and management.

The ALOS for the first year of Alliance operation presents as a higher value than the overall ALOS experienced at DCGH during the 2000-2001 period. However, these values do not include the OTSP and Corrections data. The trend is a declining ALOS that is moving toward national benchmarks. However, the ALOS of Alliance inpatients is comparable to the rate observed in short-stay hospitals nationwide. In 2000, the National Center for Health Statistics reported a rate of 6.0 days per inpatient stay. To provide better evaluation measures, a case-mix adjusted value for the overall ALOS is needed.

Recommendations

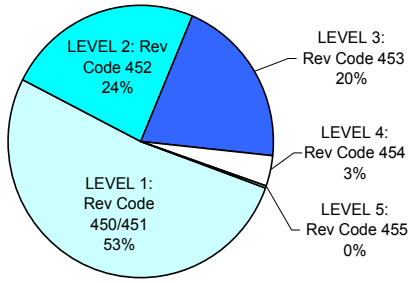
- Incorporate all provider claims, including services provided to the DOC members, in the claims database for accurate benchmarking.
- Identify the high-cost inpatient disease conditions for the first year, target the management goals, and provide technical assistance for appropriate interventions.
- Continue to monitor ALOS, identify by provider, and analyze by a severity of illness scale.

Emergency Department Utilization

Including the OTSP and Corrections services data, the emergency department services provided to the Alliance population in the first year represent:

- 15,040 emergency department claims
- 9.4 percent of the total annual paid healthcare claims
- $4,472,982 paid for emergency department claims
- 13 percent of the total sum paid for all healthcare service claims in the first year.

Chart 8.5 **EMERGENCY DEPARTMENT CLAIMS**
Percent by Level of Claim



Levels of resource utilization intensity categorize emergency department claims. Revenue codes are used to determine levels 1 through 5. The chart to the left depicts the first year ED claims sorted by level.

Table 8.8 Alliance First Year Results Emergency Department Services

Alliance First Year Results	Emergency Department Claims Excluding Urgent Care, OTSP and Corrections Data	Emergency Department Claims Including Urgent Care, OTSP, and Corrections Data	Buncombe Co. Project Access (1997) Statistics as Benchmarks
Number of ED Claims	12,515	15,040	NA
Distinct Members	8,264	NA	NA
ED Claims per Enrollee	0.33	0.40	0.26
ED Claims Paid	$3,733,767	$4,472,982	NA
Cost per ED Claim	$298.34	$297.41	NA

Source: CHP and Member Database Time Period 06/01/01 through 05/31/01 for claims paid as of October 2002

Conclusion

As noted in Section 5 of this report, the number of emergency services provided to Alliance members stabilized over the last half of the first year. Overall, emergency services made up less than 10 percent of the total claims for the first year and less than 15 percent of the overall cost of healthcare services for the first year. While we do not have equivalent utilization numbers for the population served by DCGH, these figures serve as baseline figures for the first Alliance program year and appear to be favorable.

It is not possible to determine the percentage of ED utilization by unique users within the enrolled population during the first year without the distinct number of members that were served with the OTSP and DOC claims. However, the rate of utilization by claims per enrolled member is 0.4 and compares well to the early ED utilization rate experienced by the Buncombe County safety net program.[6]

More than 50 percent of the ED claims received in the first year were reflective of the lowest levels of ED resource utilization intensity. This is appropriate for services provided at GSCH and DCGH, which are Level 1 Trauma Centers. In the future, depiction of the level of care provided at emergency departments, as contained in the OTSP values, will be helpful to determine the frequency of services provided at other hospitals.

[6] Buncombe County Medical Society's Project Access (BCMS PA) improves access to appropriate care for low income (under 200% of the Federal Poverty Level), uninsured patients of Buncombe County who are ineligible for Medicaid. The primary goal of BCMS PA is to develop and manage a coordinated system for helping uninsured people who cannot afford medical care access physician volunteer services. BCMS PA provides appropriate access to free episodic, primary and specialty care, hospital services and medications for uninsured people who cannot afford needed medical care. This program had a much smaller population for utilization study (N = 928) in 1997 and is not a managed care model; however, the goals for care and eligibility requirements are similar. Please refer to http://www.projectaccessonline.org.

Recommendations

The above figures serve as baseline values for the Alliance. The following recommendations will aid the HCSNA to improve oversight and comparative analysis for the second year of operations and beyond:

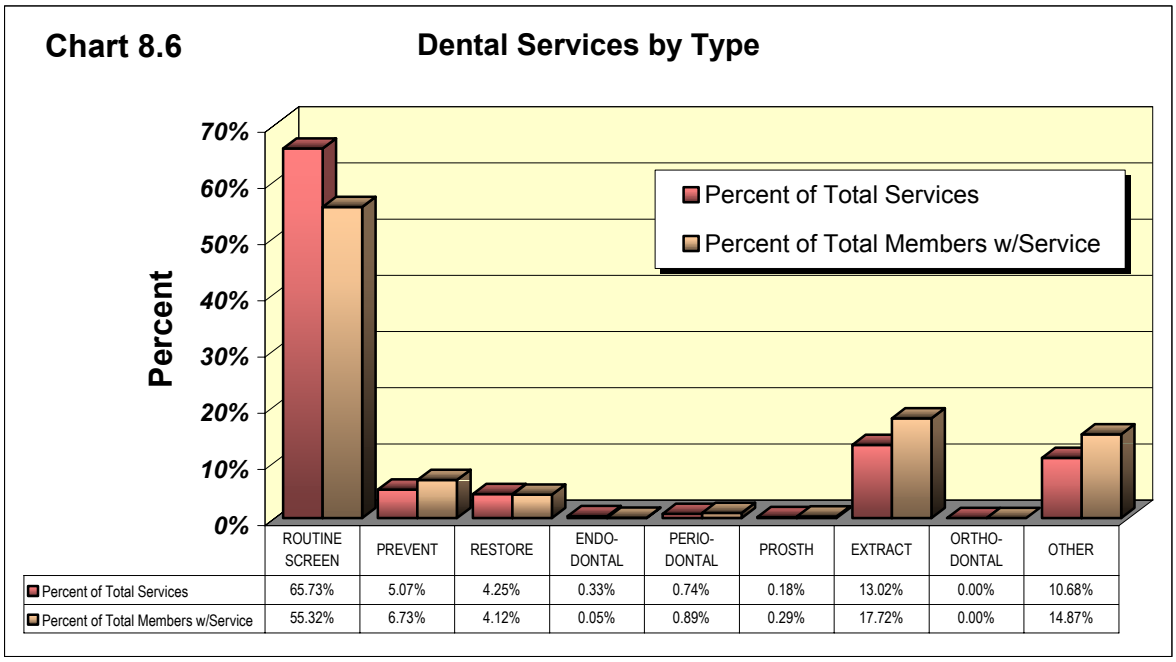
- Continue to monitor the above performance measures for comparison to other national and regional benchmarks
- Establish thresholds and goals for the above performance indicators, including frequency distribution for overall claims payment
- Continue to seek appropriate benchmarks for level-of-service comparison
- Incorporate all provider claims, including OTSP and services provided to the DOC members, in the claims database for accurate benchmarking.

Dental Service Utilization

Including the OTSP and Corrections services data, the emergency department services provided to the Alliance population in the first year represent:

- 8,161 dental claims
- 5.1 percent of the total annual paid healthcare claims
- $983,251 paid for dental claims
- 2.9 percent of the total sum paid for all healthcare service claims in the first year.

Dental services were provided at two vendor sites during the first year and consisted of approximately eight types of services. These service types and number of members is depicted on Chart 8.6, Dental Services by Type.



	ROUTINE SCREEN	PREVENT	RESTORE	ENDO-DONTAL	PERIO-DONTAL	PROSTH	EXTRACT	ORTHO-DONTAL	OTHER
Percent of Total Services	65.73%	5.07%	4.25%	0.33%	0.74%	0.18%	13.02%	0.00%	10.68%
Percent of Total Members w/Service	55.32%	6.73%	4.12%	0.05%	0.89%	0.29%	17.72%	0.00%	14.87%

Source: CHP and Member Database Time Period 06/01/01 through 05/31/01 for claims paid as of October 2002

Conclusion

Dental claims made up a small percentage of the overall claims provided in the first year. However, 66 percent of the services provided were for routine screening care. These services were provided to 55 percent of the Alliance members that received dental care. This is a favorable service frequency; however, tooth extractions accounted for 13 percent of the total services delivered, and 18 percent of the members that received dental services. This could indicate a greater need for early screening and preventative treatment, and will be a critical indicator for monitoring.

Recommendations

- Continue to monitor screening and preventative services and the overall extraction service rates provided to Alliance members
- Establish thresholds and goals for these performance indicators based on the above results
- Continue to monitor access to dental care and account for changes by comparison to the baseline service frequency distribution and national/regional benchmarks.

Pharmacy Services

One of the Alliance's primary goals is increasing prescription access to the uninsured. This goal is currently being achieved. Pharmaceutical services are administered by Unity Health Care (Unity) and are available at six sites: DC General (DCG), Southwest, Anacostia, Hunt Place, Congress Heights, and Walker Jones. These clinics were also pharmacy service sites under the Public Benefit Corporation (PBC).

The Alliance Pharmacy program began on July 16, 2001. Since then it has seen a steady increase in service use as illustrated in Chart 8.7. In its first year, the Alliance filled 183,943 prescriptions, as compared with 167,828 prescriptions processed by the PBC during the same period the year before. This represents roughly an 11 percent increase of prescriptions

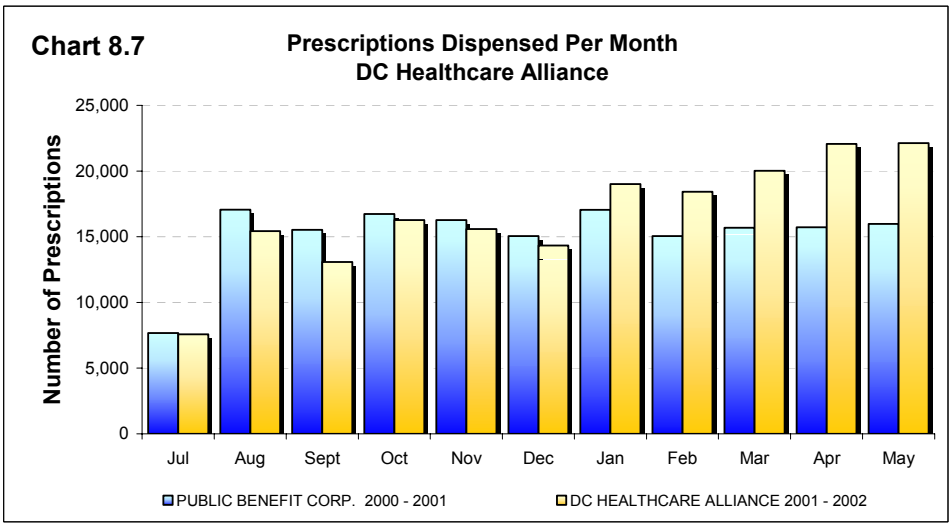
processed annually or approximately 497 additional clients served each month.

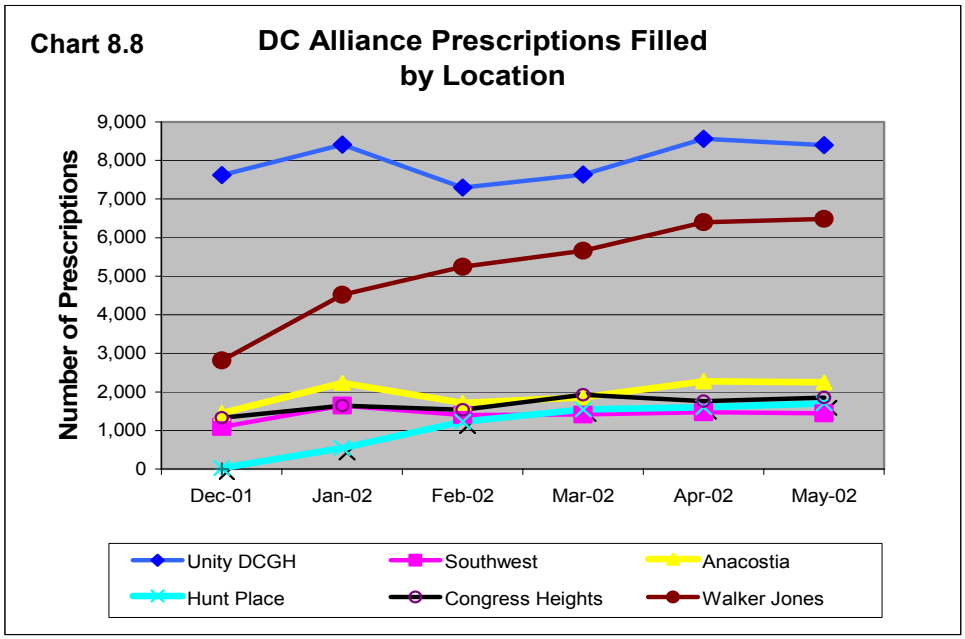
The dispensing volume increase is distributed over the clinic sites, as shown in Chart 8.8. Walker Jones saw the greatest increase in dispensing; from just under 3,000 to over 7,000 prescriptions per month. Hunt Place also experienced a relatively high dispensing rate, while DCG maintained a stable volume of prescriptions filled on-site.

Pharmacy dispensing services have also improved under the Alliance. Significant milestones include expanding the hours of operation to include holidays and expanding the Alliance Drug Formulary.

Future Goals and Objectives

Future plans for improved service and access includes extended weekday hours and weekend pharmacy access. Increasing the total number of Alliance pharmacies will also expand pharmacy





access and reduce wait time. These steps, along with surveys directed at improving customer satisfaction, will enhance the program and ultimately improve care for Alliance members.

Recommendations

Extend weekday hours and weekend pharmacy access, increase the total number of Alliance pharmacies, and assess customer satisfaction through direct surveys.